FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036533

Facility Name: WILLOW CREST NSG PAVILION

Address: 515 NORTH MAIN (Number) SANDWICH (City) 60548 (Zip Code)

County: DEKALB

Telephone Number: (815) 786-8426 **Fax #** (815) 786-6487

IDPA ID Number: 363718794001

Date of Initial License for Current Owners: 01/11/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) RICHARD S. SGARLATA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	58	Skilled (SNF)	58	21,170	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,340	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,688	3,982	2,243	13,913	8
9	SNF/PED					9
10	ICF	14,289	6,066	6	20,361	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,977	10,048	2,249	34,274	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.95%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 9 and days of care provided 1941

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	167,404	15,354	8,824	191,582		191,582		191,582			1
2	Food Purchase		149,017		149,017	(16,352)	132,665	(434)	132,231			2
3	Housekeeping	80,136	23,100		103,236		103,236		103,236			3
4	Laundry	42,887	13,725		56,612		56,612		56,612			4
5	Heat and Other Utilities			98,470	98,470		98,470	628	99,098			5
6	Maintenance	35,887	49,373	33,036	118,296		118,296	6,275	124,571			6
7	Other (specify):*							956	956			7
8	TOTAL General Services	326,314	250,569	140,330	717,213	(16,352)	700,861	7,425	708,286			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,111,352	38,438	156,552	1,306,342		1,306,342	(39)	1,306,303			10
10a	Therapy			7,180	7,180		7,180		7,180			10a
11	Activities	52,392	3,859	2,358	58,609		58,609		58,609			11
12	Social Services	31,846	1,484	2,632	35,962		35,962		35,962			12
13	Nurse Aide Training							98	98			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,195,590	43,781	169,922	1,409,293		1,409,293	59	1,409,352			16
	C. General Administration											
17	Administrative	57,341			57,341		57,341	117,039	174,380			17
18	Directors Fees											18
19	Professional Services			225,849	225,849		225,849	(181,746)	44,103			19
20	Dues, Fees, Subscriptions & Promotions			45,756	45,756		45,756	(33,822)	11,934			20
21	Clerical & General Office Expenses	22,246	3,847	27,563	53,656		53,656	35,956	89,612			21
22	Employee Benefits & Payroll Taxes			277,926	277,926	16,352	294,278	(18,399)	275,879			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,213	1,213		1,213	701	1,914			24
25	Other Admin. Staff Transportation			119	119		119	89	208			25
26	Insurance-Prop.Liab.Malpractice			91,281	91,281		91,281	2,831	94,112			26
27	Other (specify):*							18,917	18,917			27
28	TOTAL General Administration	79,587	3,847	669,707	753,141	16,352	769,493	(58,434)	711,059			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,601,491	298,197	979,959	2,879,647		2,879,647	(50,950)	2,828,697			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WILLOW CREST NSG PAVILION #0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			79,193	79,193		79,193	112,689	191,882			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,048	20,048		20,048	163,462	183,510			32
33	Real Estate Taxes			51,345	51,345		51,345	1,480	52,825			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			3,288	3,288		3,288	6,058	9,346			35
36	Other (specify):*											36
37	**TOTAL Ownership**			633,874	633,874		633,874	(196,311)	437,563			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		61,631	91,716	153,347		153,347	(484)	152,863			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,510	63,510		63,510		63,510			42
43	Other (specify):*	9,102			9,102		9,102	(9,102)				43
44	**TOTAL Special Cost Centers**	9,102	61,631	155,226	225,959		225,959	(9,586)	216,373			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,610,593	359,828	1,769,059	3,739,480		3,739,480	(256,847)	3,482,633			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,294)	30		9
10	Interest and Other Investment Income	(12,427)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(434)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(32,284)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(39,218)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (96,657)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(160,190)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (160,190)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (256,847)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WILLOW CREST NSG PAVILION

ID# 0036533

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized Repairs & Maintenance	$ (867)	6	1
2	Discounts Earned	(700)	21	2
3	Bank Service Charges	(116)	21	3
4	Marketing	(9,102)	43	4
5	Political Contributions	(2,000)	21	5
6	Prior Period Adjustment-Employee Benefits	(18,399)	22	6
7	Prior Period Adjustment-Dues & Subscriptions	(184)	20	7
8	COPE Fee ILLTC	(2,213)	20	8
9	Amortization (Building Co)	(3,350)	31	9
10	Franchise Tax (Building Co)	(200)	21	10
11	State Replacement Tax (Building)	(2,087)	21	11
12				12
13				13
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91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(434)											(434)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			628									628	5
6	Maintenance	(867)		3,255	3,887								6,275	6
7	Other (specify):*			672		284							956	7
8	**TOTAL General Services**	(1,301)		4,555	3,887	284							7,425	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records								(39)				(39)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training			98									98	13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**			98					(39)				59	16
	C. General Administration													
17	Administrative				117,039								117,039	17
18	Directors Fees													18
19	Professional Services			(181,746)									(181,746)	19
20	Fees, Subscriptions & Promotions	(34,681)		859									(33,822)	20
21	Clerical & General Office Expenses	(5,103)	2,287	34,959	3,813								35,956	21
22	Employee Benefits & Payroll Taxes	(18,399)											(18,399)	22
23	Inservice Training & Education													23
24	Travel and Seminar			701									701	24
25	Other Admin. Staff Transportation			89									89	25
26	Insurance-Prop.Liab.Malpractice			2,831									2,831	26
27	Other (specify):*			5,638		13,279							18,917	27
28	**TOTAL General Administration**	(58,183)	2,287	(136,669)	120,852	13,279							(58,434)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(59,484)	2,287	(132,016)	124,739	13,563			(39)				(50,950)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(12,294)	122,320	2,663									112,689	30
31	Amortization of Pre-Op. & Org.	(3,350)	3,350											31
32	Interest	(12,427)	174,365	1,524									163,462	32
33	Real Estate Taxes			1,480									1,480	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			6,058									6,058	35
36	Other (specify):*													36
37	TOTAL Ownership	(28,071)	(179,965)	11,725									(196,311)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(484)				(484)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(9,102)											(9,102)	43
44	TOTAL Special Cost Centers	(9,102)							(484)				(9,586)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(96,657)	(177,678)	(120,291)	124,739	13,563			(523)				(256,847)	45

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Willowcrest Building LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 480,000	Willowcrest Building LLC	100.00%	$	$ (480,000)	1
2	V	32	Interest Income				(2,681)	(2,681)	2
3	V	32	Interest Expense				177,046	177,046	3
4	V	30	Depreciation				122,320	122,320	4
5	V	31	Amortization Cost				3,350	3,350	5
6	V	21	Franchise Tax				200	200	6
7	V	21	State Replacement Tax				2,087	2,087	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 480,000			$ 302,322	$ * (177,678)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 628	$ 628	15
16	V	6	REPAIRS & MAINT.				3,255	3,255	16
17	V	7	EMP.BEN. - GEN. SERVICES				672	672	17
18	V	13	NURSES AIDE TRAINING				98	98	18
19	V	19	PROFESSIONAL FEES				1,414	1,414	19
20	V	20	DUES AND SUBSCRIPTIONS				859	859	20
21	V	21	CLERICAL & GENERAL				34,959	34,959	21
22	V	24	SEMINARS AND TRAVEL				701	701	22
23	V	25	ADMIN. STAFF TRANS.				89	89	23
24	V	26	INSURANCE				2,831	2,831	24
25	V	27	EMP.BEN. - GEN. ADMIN.				5,638	5,638	25
26	V	30	DEPRECIATION				2,663	2,663	26
27	V	32	INTEREST				1,524	1,524	27
28	V	33	REAL ESTATE TAXES				1,480	1,480	28
29	V	35	EQUIPMENT RENTAL				6,058	6,058	29
30	V								30
31	V								31
32	V								32
33	V	19	BOOKKEEPING SERVICES	183,160				(183,160)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 183,160			$ 62,869	$ * (120,291)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 3,887	$ 3,887	15
16	V	10	NURSING CMP - SUE G.						16
17	V	17	ADMIN. CMP. - M. MAUER				24,129	24,129	17
18	V	17	ADMIN. CMP. - M. AARON				32,574	32,574	18
19	V	17	ADMIN. CMP. - F. AARON				23,430	23,430	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN						20
21	V	17	ADMIN. CMP. - S. KOPLIN				6,943	6,943	21
22	V	17	ADMIN. CMP. - D. MAGAFAS				7,831	7,831	22
23	V	17	ADMIN. CMP. - E. CASSON						23
24	V	17	ADMIN. CMP. - S. BOGEN						24
25	V	17	ADMIN. CMP. - S. LEVY				8,449	8,449	25
26	V	17	ADMIN. CMP. - HOWARD ALTER						26
27	V	17	ADMIN. CMP. - NON-OWNER				13,683	13,683	27
28	V	21	CLERICAL CMP. - S. AARON				3,813	3,813	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 124,739	$ * 124,739	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 284	$ 284	15
16	V	15	EMP. BEN.- SUE G.						16
17	V	27	EMP. BEN.- M. MAUER				1,540	1,540	17
18	V	27	EMP. BEN.- M. AARON				2,246	2,246	18
19	V	27	EMP. BEN.- F. AARON				2,692	2,692	19
20	V	27	EMP. BEN.- S. GOLDSTEIN						20
21	V	27	EMP. BEN.- S. KOPLIN				1,592	1,592	21
22	V	27	EMP. BEN.- D. MAGAFAS				1,685	1,685	22
23	V	27	EMP. BEN.- E. CASSON						23
24	V	27	EMP. BEN.- S. BOGEN						24
25	V	27	EMP. BEN.- S. LEVY				1,173	1,173	25
26	V	27	EMP. BEN.- HOWARD ALTER						26
27	V	27	EMP. BEN.- NON-OWNER				1,839	1,839	27
28	V	27	EMP. BEN. - S. AARON				512	512	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 13,563	$ * 13,563	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY	$ 7,180	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	$ 7,180	$	15
16	V	19	PROFESSIONAL FEES		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			16
17	V	22	EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			17
18	V	39	ANCILLARY SERVICES	91,715	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	91,715		18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 98,895			$ 98,895	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING & MEDICAL SUPPLY	$ 4,526	PHARMCOR, L.L.C.	100.00%	$ 4,526	$	15
16	V	19	PROFESSIONAL FEES		PHARMCOR, L.L.C.	100.00%			16
17	V	21	CLERICAL & GENERAL	204	PHARMCOR, L.L.C.	100.00%	204		17
18	V	22	EMPLOYEE BENEFITS		PHARMCOR, L.L.C.	100.00%			18
19	V	39	ANICILLARY EXPENSE	44,556	PHARMCOR, L.L.C.	100.00%	44,556		19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 49,286			$ 49,286	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V	10	MEDICAL SUPPLIES	190	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	151	(39)	16
17	V	39	ANCILLARY EXPENSE	2,338	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	1,854	(484)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,528			$ 2,005	$ * (523)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marshall Mauer	Owner	Administrative	21.55%	see attached	2.4	4.84%	Dynamic Alloc	$ 24,129	17-7	1
2	Maurice Aaron	Owner	Administrative	23.79%	see attached	2.8	5.62%	Dynamic Alloc	32,574	17-7	2
3	Fred Aaron	Owner	Administrative	13.10%	see attached	5.5	12.22%	Dynamic Alloc	23,430	17-7	3
4	Sharon Aaron	Relative	Clerical		see attached	2.42	5.90%	Dynamic Alloc	3,813	21-7	4
5	Sue Koplin	Owner	Administrative	0.56%	see attached	4.34	9.64%	Dynamic Alloc	6,943	17-7	5
6	Diania Magafas	Owner	Administrative	0.56%	see attached	4.30	9.56%	Dynamic Alloc	7,831	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 98,720		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	577,359	15	$ 10,580	$	34,274	$ 628	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	577,359	15	54,834	37,633	34,274	3,255	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	577,359	15	11,326		34,274	672	3
4	13	NURSES AIDE TRAINING	PATIENT DAYS	577,359	15	1,650		34,274	98	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	577,359	15	23,811		34,274	1,414	5
6	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	577,359	15	14,469		34,274	859	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	577,359	15	588,891	487,646	34,274	34,959	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	577,359	15	11,803		34,274	701	8
9	25	ADMIN. STAFF TRANS.	PATIENT DAYS	577,359	15	1,502		34,274	89	9
10	26	INSURANCE	PATIENT DAYS	577,359	15	47,685		34,274	2,831	10
11	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	577,359	15	94,969		34,274	5,638	11
12	30	DEPRECIATION	PATIENT DAYS	577,359	15	44,866		34,274	2,663	12
13	32	INTEREST	PATIENT DAYS	577,359	15	25,667		34,274	1,524	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	577,359	15	24,936		34,274	1,480	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	577,359	15	102,054		34,274	6,058	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,059,043	$ 525,279		$ 62,869	25

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	12	62,194	62,194	3	3,887	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	45,894	45,894			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	13	398,821	398,821	2	24,129	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	45	12	521,536	521,536	3	32,574	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	191,700	191,700	6	23,430	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	50	3	161,003	161,003			6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	45	8	71,993	71,993	4	6,943	7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	8	81,938	81,938	4	7,831	8
9	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	38	1	47,846	47,846			9
10	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	3	96,858	96,858			10
11	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	55	13	139,807	139,807	3	8,449	11
12	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	9,000	9,000			12
13	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	13	219,069	219,069	3	13,683	13
14	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	13	63,022	63,022	2	3,813	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,110,681	$ 2,110,683		$ 124,739	25

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40		4,545		3	284	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40		3,924				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40		25,461		2	1,540	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	45		35,957		3	2,246	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45		22,028		6	2,692	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	50		20,193				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	45		16,504		4	1,592	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45		17,632		4	1,685	8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	38		11,976				9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45		6,849				10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	55		19,408		3	1,173	11
12	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40		1,068				12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45		29,449		3	1,839	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40		8,457		2	512	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 223,451	$		$ 13,563	25

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS, L.L.C.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION						7,180	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION							2
3	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							3
4	39	ANCILLARY SERVICES	DIRECT ALLOCATION						91,715	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 98,895	25

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PHARMCOR, L.L.C.
Street Address 3116 S. OAK PARK
City / State / Zip Code BERWYN, IL 60402
Phone Number (708)795-7701
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION						4,526	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION							2
3	21	CLERICAL & GENERAL	DIRECT ALLOCATION						204	3
4	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							4
5	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						44,556	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 49,286	25

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						151	2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						1,854	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,005	25

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	American National Bank		X	Mortgage			$ 3,350,000	$ 2,568,017			$ 177,046	1
2												2
3												3
4												4
5												5
	Working Capital											
6	American National Bank		X					496,000			20,048	6
7												7
8												8
9	TOTAL Facility Related						$ 3,350,000	$ 3,064,017			$ 197,094	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	Interest Income										(12,427)	11
12	Dynamic Allocation										1,524	12
13	Interest Income (Bldg. Co.)										(2,681)	13
14	TOTAL Non-Facility Related						$	$			$ (13,584)	14
15	TOTALS (line 9+line14)						$ 3,350,000	$ 3,064,017			$ 183,510	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 51,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 51,825	2
3. Under or (over) accrual (line 2 minus line 1).		$ 825	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 52,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 52,825	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	31,736	8
	1997	32,926	9
	1998	48,905	10
	1999	49,489	11
	2000	50,345	12

2001 Accrual = 2000 RE Tax + 3%
$50,345 x 103% = 51,855 (Rounded to $52,000)

Dynamic Allocation: 1480

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WILLOW CREST NSG PAVILION COUNTY DEKALB

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-26-433-024	Facility	$ 50,345.14	$ 50,345.14
2.	10-23-404-059-0000	Home Office Allocation	$ 24,139.10	$ 1,432.98
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 74,484.24	$ 51,778.12

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,430 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1998	$ 327,859	1
2					2
3	TOTALS			$ 327,859	3

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	21,410		20	1,071	1,071	12,315	9
10	Various			1991	9,997		20	418	418	9,918	10
11	Various			1992	4,279		20	214	214	2,042	11
12	Various			1993	26,868		20	1,344	(1,344)	11,255	12
13	Various			1994	8,312		20	416	416	3,136	13
14	Various			1995	3,234		20	162	162	1,059	14
15	Various			1996	17,411		20	870	870	4,498	15
16	Various			1997	68,499		20	3,425	3,425	13,815	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,571,067	65,925		66,308	383	207,282	68
69	Financial Statement Depreciation			15,024			(15,024)		69
70	TOTAL (lines 4 thru 69)		$ 2,731,077	$ 80,949		$ 74,228	$ (9,409)	$ 265,320	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,731,077	$ 80,949		$ 74,228	$ (6,721)	$ 265,320	1
2	BOILER REPAIR	1998	1,973		20	99	99	363	2
3	SHADE	1998	404		20	20	20	72	3
4	CEILING FIXTURES & L	1998	2,479		20	124	124	434	4
5	CEILING TILE	1998	1,732		20	87	87	305	5
6	COVE BASE	1998	379		20	19	19	67	6
7	CEILING FIXTURE	1998	1,134		20	57	57	195	7
8	HANDRAILS & GUARDS	1998	6,707		20	335	335	1,145	8
9	A/C COMPRESSORS	1998	404		20	20	20	63	9
10	SPRINKLER HEADS	1998	974		20	49	49	159	10
11	SPRINKLER HEADS	1998	703		20	35	35	108	11
12	HANDRAILS	1999	14,756		20	738	738	2,214	12
13	HOT WATER BOILER	1999	6,563		20	328	328	984	13
14	HOT WATER BOILER	1999	9,018		20	451	451	1,353	14
15	CUBICLE	1999	506		20	25	25	75	15
16	DYNALOCK SYSTEM	1999	4,966		20	248	248	723	16
17	NURSES STATION	1999	9,316		20	466	466	1,359	17
18	ENTRANCE DOOR	1999	1,898		20	95	95	277	18
19	DOOR	1999	557		20	28	28	82	19
20	HAND RAILS & BUMPERS	1999	4,438		20	222	222	629	20
21	ATRIUM A/C	1999	5,755		20	288	288	816	21
22	CAMERAS & MONITORS	1999	2,750		20	138	138	391	22
23	DOOR/FRAME	1999	553		20	28	28	79	23
24	GENERATOR	1999	14,595		20	730	730	2,068	24
25	CURTAINS/DRAPES	1999	2,013		20	101	101	261	25
26	WINDOW TREATMENTS	1999	5,002		20	250	250	646	26
27	SOLFIT & FACCIA	1999	4,970		20	249	249	643	27
28	TILE	1999	2,087		20	104	104	260	28
29	TILE	1999	302		20	15	15	38	29
30	SOLFIT & FACCIA	1999	5,322		20	266	266	687	30
31	NEW FLOORS	1999	2,310		20	116	116	271	31
32	COVE CASE	1999	459		20	23	23	54	32
33	NEW ENT EDGING	1999	1,286		20	64	64	149	33
34	TOTAL (lines 1 thru 33)		$ 2,847,388	$ 80,949		$ 80,046	$ (903)	$ 282,290	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,847,388	$ 80,949		$ 80,046	$ (903)	$ 282,290	1
2	COVE BASE	1999	459		20	23	23	52	2
3	FLOOR TILES	1999	2,022		20	101	101	227	3
4	CEILING TILE	1999	236		20	12	12	27	4
5	FLOOR TILES	1999	2,364		20	118	118	266	5
6	GENERATOR SYSTEM	1999	29,189		20	1,459	1,459	2,363	6
7	GENERATOR SYSTEM UPG	1999	5,496		20	275	275	596	7
8	ELEVATOR REPAIRS	1999	435		20	11	11	23	8
9	ELEVATOR REPAIRS	1999	1,031		20	26	26	55	9
10	ELEVATOR REPAIRS	1999	311		20	8	8	17	10
11	SHOWER TILE	1999	591		20	15	15	31	11
12	AIR CONDITIONER	1999	1,098		20	55	55	220	12
13	AIR CONDITIONER	1999	1,098		20	55	55	211	13
14	AIR CONDITIONER	1999	1,098		20	55	55	202	14
15	AIR CONDITIONER	1999	1,098		20	55	55	193	15
16	AIR CONDITIONER	1999	1,098		20	55	55	183	16
17	AIR CONDITIONER	1999	1,098		20	55	55	183	17
18	BORDER	1999	192		20	10	10	20	18
19	WALLPAPER	1999	586		20	29	29	58	19
20	WALLPAPER	1999	670		20	34	34	68	20
21	WALL GUARD	1999	1,170		20	59	59	118	21
22	WALLPAPER	1999	1,245		20	62	62	124	22
23	WALLPAPER	1999	5,192		20	260	260	520	23
24	ROOM SIGNAGES	1999	1,323		20	66	66	132	24
25	COOLING REPAIRS	1999	542		20	27	27	54	25
26	BATHROOM FIXTURES	1999	600		20	30	30	60	26
27	FIRE ALARM	1999	1,140		20	57	57	114	27
28	PLUMBING WORK	1999	1,040		20	52	52	104	28
29	ROOF RENOVATION	2000	23,155		20	1,158	1,158	2,316	29
30	SHOWER REMODELING	2000	673		20	34	34	68	30
31	SHOWER REMODELING	2000	638		20	32	32	64	31
32	FIRE DOORS	2000	1,939		20	97	97	194	32
33	TILE & COVE BASE	2000	838		20	42	42	81	33
34	TOTAL (lines 1 thru 33)		$ 2,937,053	$ 80,949		$ 84,473	$ 3,524	$ 291,234	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,937,053	$ 80,949		$ 84,473	$ 3,524	$ 291,234	1
2	TILE	2000	1,791		20	90	90	173	2
3	COVE BASE	2000	462		20	23	23	44	3
4	WATER HEATER REPAIR	2000	2,081		20	104	104	191	4
5	SECURITY CAMERAS	2000	1,925		20	96	96	176	5
6	CUBICLE HOOKS	2000	112		20	6	6	11	6
7	TILES	2000	507		20	25	25	46	7
8	CUBICLE TRACKS&CURTA	2000	507		20	25	25	46	8
9	TILE	2000	1,912		20	96	96	176	9
10	SHOWER REMODELING	2000	405		20	20	20	35	10
11	TILE	2000	699		20	35	35	61	11
12	BUZZERS	2000	175		20	9	9	16	12
13	WATER TANK REPAIR	2000	667		20	33	33	58	13
14	ELEVATOR DOOR EDGE	2000	2,270		20	114	114	190	14
15	TILE	2000	210		20	11	11	17	15
16	BOILER REPAIR	2000	458		20	23	23	36	16
17	KICK PLATES	2000	392		20	20	20	32	17
18	SECURITY MONITOR	2000	290		20	15	15	25	18
19	BATHROOM TILE	2000	30,000		20	1,500	1,500	2,375	19
20	BATHROOM TILE	2000	15,000		20	750	750	1,188	20
21	DINING ROOM TILES	2000	4,500		20	225	225	356	21
22	ROOF REPAIR	2000	1,425		20	71	71	124	22
23	SPRINKLER REPAIR	2000	1,625		20	81	81	122	23
24	LIGHTING	2000	1,770		20	89	89	134	24
25	WATER PUMP	2000	1,567		20	78	78	111	25
26	TILE	2000	1,792		20	90	90	128	26
27	FIXTURES	2000	1,587		20	79	79	105	27
28	COVE BASE	2000	318		20	16	16	21	28
29	TILE	2000	2,599		20	130	130	173	29
30	FAUCETS	2000	699		20	35	35	47	30
31	BATHROOM SINKS	2000	538		20	27	27	36	31
32	BATHROOM SINKS&FAUCE	2000	1,072		20	54	54	72	32
33	TILE	2000	5,425		20	271	271	384	33
34	TOTAL (lines 1 thru 33)		$ 3,021,833	$ 80,949		$ 88,714	$ 7,765	$ 297,943	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,021,833	$ 80,949		$ 88,714	$ 7,765	$ 297,943	1
2	COVE BASE	2000	837		20	42	42	53	2
3	WALL GUARDS	2000	589		20	29	29	36	3
4	WALL BORDERS	2000	1,772		20	89	89	111	4
5	SOUND SYSTEM	2000	840		20	42	42	53	5
6	TILE	2000	307		20	15	15	20	6
7	TILE	2000	205		20	10	10	13	7
8	DEFROST CLOCK	2000	725		20	36	36	42	8
9	FIRE PANELS	2000	2,887		20	144	144	168	9
10	WALL BORDERS	2000	1,828		20	91	91	106	10
11	CARPETING	2000	5,270		20	264	264	330	11
12	TILING & DRYWALL	2000	5,900		20	295	295	320	12
13	COOLER REPAIR	2000	719		20	36	36	39	13
14	DOOR	2000	320		20	16	16	17	14
15	WALLPAPER	2000	3,919		20	196	196	245	15
16	WALLPAPER	2000	3,066		20	153	153	204	16
17	PARKING LOT PAVING	2000	8,775		20	439	439	439	17
18	REMODEL STAIRWELL	2001	1,080		20	18	18	18	18
19	DOORS & REFINISHING	2001	13,510		20	338	338	338	19
20	DOORS & REFINISHING	2001	1,725		20	36	36	36	20
21	DOORS & REFINISHING	2001	100		20	2	2	2	21
22	DOORS & REFINISHING	2001	1,925		20	40	40	40	22
23	DOORS & REFINISHING	2001	900		20	19	19	19	23
24	DOORS & REFINISHING	2001	300		20	5	5	5	24
25	DOORS & REFINISHING	2001	300		20	5	5	5	25
26	DOORS & REFINISHING	2001	1,300		20	22	22	22	26
27	DOORS & REFINISHING	2001	900		20	15	15	15	27
28	DOORS & REFINISHING	2001	600		20	10	10	10	28
29	BATHROOM IMPRVMNT	2001	641		20	13	13	13	29
30	DINING RM TILE	2001	720		20	15	15	15	30
31	BATHROOM FAUCET	2001	725		20	15	15	15	31
32	BATHROOM FIXTURES	2001	2,434		20	51	51	51	32
33	DRYWALL MAT'L FOR 2F	2001	375		20	8	8	8	33
34	TOTAL (lines 1 thru 33)		$ 3,087,327	$ 80,949		$ 91,223	$ 10,274	$ 300,751	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,087,327	$ 80,949		$ 91,223	$ 10,274	$ 300,751	1
2	DOOR FRAME	2001	315		20	7	7	7	2
3	TILE	2001	424		20	9	9	9	3
4	DOORS	2001	1,096		20	23	23	23	4
5	DOOR HINGES	2001	237		20	5	5	5	5
6	DOORS	2001	392		20	8	8	8	6
7	TILE	2001	198		20	4	4	4	7
8	BATHROOM FIXTURES	2001	228		20	5	5	5	8
9	BATHROOM FIXTURES	2001	821		20	17	17	17	9
10	BATHROOM FLOOR	2001	1,610		20	27	27	27	10
11	WALL GUARD	2001	715		20	12	12	12	11
12	WALL COVERING	2001	3,920		20	65	65	65	12
13	BATHROOM FLOOR	2001	3,283		20	55	55	55	13
14	LIGHT FIXTURES	2001	337		20	6	6	6	14
15	BATHROOM FIXTURES	2001	407		20	7	7	7	15
16	BATHROOM FIXTURES	2001	350		20	6	6	6	16
17	DOOR	2001	495		20	15	15	15	17
18	DOOR	2001	42		20	1	1	1	18
19	DOOR	2001	171		20	5	5	5	19
20	REPAIR CONCRETE IN R	2001	260		20	7	7	7	20
21	CARPET FOR REHAB RM	2001	493		20	13	13	13	21
22	REPAIR IFRE ALARM SY	2001	633		20	16	16	16	22
23	FIXTURES FOR REHAB R	2001	192		20	5	5	5	23
24	DOOR LOCKS	2001	367		20	9	9	9	24
25	FIXTURES FOR REHAB	2001	170		20	5	5	5	25
26	FIXTURES FOR REHAB R	2001	527		20	13	13	13	26
27	FIXTURES FOR REHAB R	2001	407		20	10	10	10	27
28	DOOR FRAMES	2001	315		20	8	8	8	28
29	CEILING TILE	2001	170		20	5	5	5	29
30	KICK PLATES FOR DRS	2001	1,591		20	40	40	40	30
31	NURSES STATION	2001	9,066		20	227	227	227	31
32	FIXTURES	2001	408		20	10	10	10	32
33	BATHROOM FLOOR	2001	1,375		20	29	29	29	33
34	TOTAL (lines 1 thru 33)		$ 3,118,342	$ 80,949		$ 91,897	$ 10,948	$ 301,425	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,118,342	$ 80,949		$ 91,897	$ 10,948	$ 301,425	1
2	WOOD STRIPS FOR THER	2001	3,929		20	82	82	82	2
3	CARPETING	2001	547		20	11	11	11	3
4	DECORATIVE MURAL	2001	1,286		20	27	27	27	4
5	REPAIR OF WATER SOFT	2001	2,418		20	121	121	121	5
6	DOOR	2001	1,295		20	60	60	60	6
7	REPAIR WATER HEATER	2001	1,956		20	90	90	90	7
8	FLOORING	2001	2,104		20	96	96	96	8
9	FLOORING	2001	2,517		20	116	116	116	9
10	INSTALL MAGNETICS LO	2001	589		20	22	22	22	10
11	DOORS	2001	328		20	12	12	12	11
12	STORE ROOM LOCK	2001	216		20	8	8	8	12
13	DOOR HANDLES	2001	309		20	11	11	11	13
14	DOOR HANDLES	2001	141		20	5	5	5	14
15	SHELVES	2001	717		20	27	27	27	15
16	NURSES STATION	2001	9,066		20	302	302	302	16
17	SHELVING	2001	480		20	16	16	16	17
18	DOOR KICK PLATES	2001	229		20	7	7	7	18
19	DOORS	2001	1,025		20	34	34	34	19
20	DRYWALL HALLS, NEW C	2001	2,650		20	89	89	89	20
21	STAIN FOR DOORS	2001	228		20	7	7	7	21
22	SIGNS	2001	744		20	22	22	22	22
23	CUSTOM WALL CABINETS	2001	9,266		20	270	270	270	23
24	DOORS	2001	429		20	12	12	12	24
25	WOODSTRIPS	2001	268		20	3	3	3	25
26	WALLPAPER	2001	1,980		20	25	25	25	26
27	FOOT RAILS	2001	1,962		20	25	25	25	27
28	WALLCOVERING	2001	2,793		20	35	35	35	28
29	WALLPAPER	2001	4,500		20	56	56	56	29
30	2ND FLOOR BULBS	2001	195		20	3	3	3	30
31	DOOR & REFINISHING	2001	1,500		20	19	19	19	31
32	SIGNS	2001	1,938		20	16	16	16	32
33	WALLPAPER & PLASTER	2001	3,400		20	28	28	28	33
34	TOTAL (lines 1 thru 33)		$ 3,179,347	$ 80,949		$ 93,554	$ 12,605	$ 303,082	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,179,347	$ 80,949		$ 93,554	$ 12,605	$ 303,082	1
2	ELEVATOR VOICE ACTIV	2001	1,500		20	13	13	13	2
3	DOOR LOCKS	2001	1,705		20	14	14	14	3
4	DOOR WIRING	2001	3,000		20	13	13	13	4
5	REMODELING - 2FL	2001	13,885		20	58	58	58	5
6	PLUMBING	2001	867		20	43	43	43	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,200,304	$ 80,949		$ 93,695	$ 12,746	$ 303,223	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,200,304	$ 80,949		$ 93,695	$ 12,746	$ 303,223	1
2									2
3									3
4									4
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,200,304	$ 80,949		$ 93,695	$ 12,746	$ 303,223	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1998		$ 2,544,733	$ 65,250	39	$ 65,250	$	$ 198,469	4
5	Dyn Alloc		1996		26,334	675		1,058	383	8,813	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
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63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,571,067	$ 65,925		$ 66,308	$ 383	$ 207,282	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 749,329	$ 121,330	$ 91,076	$ (30,254)	10	$ 135,754	71
72	Current Year Purchases	47,493	41	2,887	2,846	10	2,887	72
73	Fully Depreciated Assets	13,109				10	13,109	73
74								74
75	TOTALS	$ 809,931	$ 121,371	$ 93,963	$ (27,408)		$ 151,750	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		DODGE WAGON	1994	$ 27,533	$ 1,675	$ 2,753	$ 1,078	5	$ 20,418	76
77	Dynamic Allocation	Vehicle-Dynamic Allocation	2001	3,342	182	1,472	1,290	5	1,472	77
78										78
79										79
80	TOTALS			$ 30,875	$ 1,857	$ 4,225	$ 2,368		$ 21,890	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,368,969	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 204,177	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 191,883	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,294)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 476,863	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 9,346 Description: Toshiba Copier-$2580 Bobcat/Saw-$708 Dynamic Allocation-$6058
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				Dynamic
7	Contractual Payments				Alloc
8	Nurse Aide Competency Tests		98		98
9	TOTALS	$	$ 98	$	$ 98
10	SUM OF line 9, col. 1 and 2 (e)	$ 98			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 42,293	$		$ 42,293	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			2,327			2,327	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			47,096			47,096	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				52,784		52,784	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						8,847		8,847	13
14	TOTAL			$		$ 91,716	$ 61,631		$ 153,347	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 45,388	$ 132,268	1
2	Cash-Patient Deposits	30,975	30,975	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	450,197	450,197	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,358	34,358	6
7	Other Prepaid Expenses	3,084	3,084	7
8	Accounts Receivable (owners or related parties)	172,355	203,955	8
9	Other(specify): See supplemental schedule	19,368	2,129	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 755,725	$ 856,966	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		327,859	13
14	Buildings, at Historical Cost		2,544,733	14
15	Leasehold Improvements, at Historical Cost	592,403	592,403	15
16	Equipment, at Historical Cost	423,646	829,646	16
17	Accumulated Depreciation (book methods)	(336,971)	(798,765)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,000	6,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,000)	(6,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule		23,310	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 679,078	$ 3,519,186	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,434,803	$ 4,376,152	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 188,227	$ 188,226	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,975	30,975	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	132,474	132,474	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,394	2,394	31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,000	52,000	32
33	Accrued Interest Payable	2,018	11,671	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,864	5,864	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 413,952	$ 423,604	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	496,000	496,000	39
40	Mortgage Payable		2,568,017	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 496,000	$ 3,064,017	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 909,952	$ 3,487,621	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 524,851	$ 888,531	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,434,803	$ 4,376,152	48

*(See instructions.)

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 551,989	1	
2	Restatements (describe):		2	
3	2000 Late Journal Entry - State Income Tax	(2,645)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 549,344	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	114,707	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(139,200)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (24,493)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 524,851	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,801,388	1
2	Discounts and Allowances for all Levels	(429,689)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,371,699	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	363,460	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 363,460	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	79,178	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,488	19
20	Radiology and X-Ray		20
21	Other Medical Services	18,235	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 105,901	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,427	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,427	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	700	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 700	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,854,187	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	717,213	31
32	Health Care	1,409,293	32
33	General Administration	753,141	33
	B. Capital Expense		
34	Ownership	633,874	34
	C. Ancillary Expense		
35	Special Cost Centers	162,449	35
36	Provider Participation Fee	63,510	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,739,480	40
41	**Income before Income Taxes (line 30 minus line 40)****	114,707	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 114,707	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,809	1,930	$ 42,035	$ 21.78	1
2	Assistant Director of Nursing	2,117	2,188	51,840	23.69	2
3	Registered Nurses	6,648	7,111	141,077	19.84	3
4	Licensed Practical Nurses	13,806	15,085	303,219	20.10	4
5	Nurse Aides & Orderlies	53,360	55,575	555,820	10.00	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,963	2,170	24,184	11.14	9
10	Activity Assistants	4,316	4,424	28,208	6.38	10
11	Social Service Workers	3,183	3,527	31,846	9.03	11
12	Dietician					12
13	Food Service Supervisor	1,882	2,082	29,034	13.95	13
14	Head Cook	4,306	4,592	46,853	10.20	14
15	Cook Helpers/Assistants	13,061	13,547	91,517	6.76	15
16	Dishwashers					16
17	Maintenance Workers	3,010	3,099	35,887	11.58	17
18	Housekeepers	11,148	11,677	80,136	6.86	18
19	Laundry	6,801	6,919	42,887	6.20	19
20	Administrator	1,965	2,211	57,341	25.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,385	2,618	22,246	8.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,472	1,609	17,361	10.79	31
32	Other Health Care(specify)					32
33	Other(specify)	616	684	9,102	13.31	33
34	TOTAL (lines 1 - 33)	133,848	141,048	$ 1,610,593 *	$ 11.42	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	211	$ 8,824	01-03	35
36	Medical Director	119	1,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	51	1,616	10-03	38
39	Pharmacist Consultant	96	3,625	10-03	39
40	Physical Therapy Consultant	106	4,220	10a-03	40
41	Occupational Therapy Consultant	74	2,960	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	80	2,358	11-03	44
45	Social Service Consultant	47	2,632	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	784	$ 27,435		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	111	$ 22,900	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	6,583	128,411	10-03	52
53	TOTAL (lines 50 - 52)	6,694	$ 151,311		53

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pam Ingold	Administrator		$ 57,341
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 57,341

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners, Inc.	Unempl Consultant	$ 1,097
FR&R	Accounting	23,992
Sachnoff & Weaver	Legal	7,012
Littler Medelson, PC	Legal	5,889
Econocare, Inc.	Purchasing Consultant	2,088
Dynamic Health Care	Bookkeeping Services	183,160
Health Data Systems	Data Processing	2,611
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 225,849

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,330
Unemployment Compensation Insurance	14,981
FICA Taxes	121,688
Employee Health Insurance	79,311
Employee Meals	16,352
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	5,217
TOTAL (agree to Schedule V, line 22, col.8)	$ 275,879

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	6,850
Health Care Worker Background Check (Indicate # of checks performed 33)	253
Dues & Subscriptions	5,143
Advertising & Promotion	27,975
Yellow Pages	4,310
Licenses & Fees	843
Dynamic Allocation	859
Less: Public Relations Expense	
Non-allowable advertising	(27,975)
Yellow page advertising	(4,310)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,147

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,213
Dynamic Allocation	701
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,914

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	WALLPAPER	12/96	$ 4,919	3	$ 1,640	$ 1,503	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,919		$ 1,640	$ 1,503	$	$	$	$	$	$	$

Facility Name & ID Number WILLOW CREST NSG PAVILION # 0036533 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILLINOIS COUNCIL ON LTC-$3687.64

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 493 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 63,510
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 16,352 Has any meal income been offset against related costs? NO Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees